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IN THE MATTER OF:

MARY HAZEL SPROLES (survivor of deceased miner JAMES SPROLES),
Claimant,

Date: June 29, 2001

v.

Case No.: 1995-BLA-2167

BULLION HOLLOW COAL CO.,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

DECISION AND ORDER AWARDING SURVIVOR'S BENEFITS ON REMAND

This case arises from a claim for benefits filed under the Black Lung Benefits Act, as amended, at 30 U.S.C. § 901 *et seq*. ("Act"), and the implementing regulations thereunder at 20 C.F.R. Parts 718 and 725. By *Decision and Order* dated November 30, 2000, the Benefits Review Board (Board) vacated the undersigned Administrative Law Judge's award of survivor's benefits and remanded this case for reconsideration of the medical evidence under 20 C.F.R. §§ 718.202(a)(4) and 718.205(c). In particular, the Board required a re-evaluation of the qualifications of Drs. Robinette, Sargent, Barongan, Renn, and Castle and an analyses of the probative value of their medical opinions in light of underlying documentation, reasoning, and "sophistication." Moreover, the Board held that all types of evidence under 20 C.F.R. § 718.202(a) must be weighed together to determine whether the miner suffers from coal workers' pneumoconiosis pursuant to the Fourth Circuit's decision in *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

I
Collateral Estoppel and Law of the Case

Initially, The Board did not consider its own precedent regarding collateral estoppel in survivors'

claims as reflected by *Hughes v. Clinchfield Coal Co.*, 21 B.L.R.. 1-134 (1999) and *Young v. Sewell Coal Co.*, BRB No. 98-1000 BLA (Aug. 26, 1999). In *Hughes*, coal workers' pneumoconiosis was established in the living miner's claim, although the claim itself was denied. The Board held that, because (1) the finding of pneumoconiosis was not a "critical and necessary" part of the final decision in the miner's claim, and (2) autopsy evidence was presented in the survivor's claim, then the employer was not collaterally estopped from re-litigating the issue of whether the miner suffered from coal workers' pneumoconiosis in conjunction with the survivor's claim. However, this decision left open the possibility that, where pneumoconiosis supported an award of living miner's benefits, and there was no autopsy evidence offered in support of the survivor's claim, then collateral estoppel would preclude re-litigation of the issue by the employer.

In *Young*[1], the Board held that it was error for an administrative law judge to permit the employer to re-litigate the issue of the existence of pneumoconiosis in a survivor's claim, where the disease was established in support of the award of living miner's benefits and no autopsy evidence was offered in the survivor's claim. In so holding, the Board held that collateral estoppel was applicable because both the miner and survivor must establish pneumoconiosis under the same methods at 20 C.F.R. § 718.202(a). The Board in *Young* noted that the employer "was provided a full and fair opportunity to litigate this issue inasmuch as the survivor's claim (did) not contain any autopsy evidence which was not available and could not have been adduced at the time of the adjudication of the miner's claim." Consequently, the Board remanded the case to the administrative law judge for a determination of whether the disease "hastened" the miner's death as required by 20 C.F.R. § 718.205(c).

Identical facts are presented in this case. The miner died on November 11, 1994 and the survivor filed her claim on December 5, 1994, prior to Administrative Law Judge Roketenetz's January 19, 1995 decision awarding benefits on the miner's claim. Employer challenged the findings of total disability due to coal workers' pneumoconiosis before the Board and Fourth Circuit Court of Appeals and lost. Indeed, in its unpublished decision dated June 6, 1997, the Fourth Circuit stated the following:

> Bullion also challenges the ALJ's findings that Sproles suffered from pneumoconiosis under 20 C.F.R. § 718.202(a)(4) . . ..
>
> We have carefully reviewed both the ALJ's opinion, and the Board's decision affirming the ALJ's decision. The ALJ thoroughly explained and supported each of these holdings. As such, the Board committed no error in affirming the ALJ.

Turning to Judge Roketenetz's decision, it is noted that he found the presence of coal workers' pneumoconiosis based on the following:

> After reviewing all the medical reports, I find the persuasive reports of record establish the presence of pneumoconiosis. I note that the examining physicians all found

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[1] A copy of the decision is attached.

> pneumoconiosis present, including Drs. Paranthaman, Nash, and Sargent. I find Dr. Sargent's finding of pneumoconiosis particularly persuasive since he performed his examination at the request of the Employer. In addition, Dr. Sargent noted that the x-ray findings were not usual for coal workers' pneumoconiosis, but were not unheard of, either. I credit his conclusion as an examining physician and a pulmonary specialist over the opinions of the reviewing physicians, Drs. Renn and Castle, also qualified as pulmonary specialists, whose conclusions of no pneumoconiosis were based, in large part, on the negative chest x-ray reports. These physicians did not have the more complete medical evidence Dr. Sargent had in actually reviewing the x-ray film as well as the miner's physical condition. In addition, Dr. Sargent's conclusions are well-supported by the report of Dr. Robinette, also qualified as a pulmonary specialist, who raised questions about the validity of the negative chest x-ray reports in light of the ILO x-ray guidelines. Under these circumstances, I find Dr. Sargent's conclusion that pneumoconiosis is present as supported by the examination findings of Drs. Nash and Paranthaman and the review findings of Dr. Robinette, probative and more persuasive than the reviewing findings of Drs. Renn and Castle. Accordingly, I find the presence of pneumoconiosis is established by the probative medical opinion reports under the provisions of § 718.202(a)(4).

The undersigned adopts and incorporates the foregoing findings of fact and conclusions of law regarding the existence of coal workers' pneumoconiosis under § 718.202(a)(4).

By *Affidavit of Widow* dated June 30, 2001, Claimant states that no autopsy was conducted on the miner. The "newly" submitted evidence in the survivor's claim only consists of hospitalization and treatment records from 1991 through 1994 and the November 21, 1994 death certificate completed by Dr. Barongan wherein he concludes that the immediate causes of the miner's death were acute respiratory failure and chronic obstructive lung disease. *Director's Exhibit* (*Dx*.) 6 and 9-35. Secondary conditions contributing to the miner's death were listed as arteriosclerotic heart disease with cor pulmonale. The hospitalization records reveal that Dr. Barongan treated the miner for heart disease, recurrent respiratory failure, severe chronic obstructive pulmonary disease, and pneumoconiosis among other conditions. Dr. Barongan issued a *Certificate of Medical Necessity* dated October 21, 1994 wherein he stated that the miner's last dates of hospitalization were from September 20, 1994 to October 19, 1994 and he was treated for respiratory failure, bronchitis, and chronic obstructive pulmonary disease. *Dx*. 38. At the time, Dr. Barongan prescribed a bedside commode and semi-electric hospital bed for the miner upon his discharge from the hospital. Because there was no autopsy of the miner, Employer merely re-submitted the 16 exhibits which pre-date Judge Roketenetz's decision and which contain no new bases for finding an absence of pneumoconiosis beyond those bases which were considered by Judge Roketenetz, the Board, and the Fourth Circuit in the living miner's claim.

Based on the foregoing, it is evident that Employer is collaterally estopped under *Hughes* and *Young* from re-litigating the issue of whether the miner suffers from coal workers' pneumoconiosis. Moreover, the Fourth Circuit's affirmance of Judge Roketenetz's weighing of the medical opinion evidence under 20 C.F.R. §§ 718.202(a)(1) and 718.202(a)(4) constitutes law of the case. *See e.g., Brinkley v.*

Peabody Coal Co., 14 B.L.R. 1-147, 1-151 (1990); *Dean v. Marine Terminals Corp.*, 15 B.R.B.S. 394 (1983).

II
Weighing all evidence under § 718.202 together

Subsequent to the decisions issued in the living miner's claim, the Fourth Circuit issued its decision in *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000). Under the facts of that case, the administrative law judge concluded that the miner did not establish pneumoconiosis through chest x-ray evidence under § 718.202(a)(1), but he did find that pneumoconiosis was established via medical opinion evidence at § 718.202(a)(4). The Fourth Circuit vacated this finding and held that the administrative law judge must weigh all the evidence under 20 C.F.R. § 718.202 together to determine whether the miner suffered from the disease. In so holding, the court stated the following:

> [W]eighing all of the relevant evidence together makes common sense. Otherwise, the existence of pneumoconiosis could be found even though the evidence as a whole clearly weighed against such a finding. For example, suppose x-ray evidence indicated that the miner had pneumoconiosis, but autopsy evidence established that the miner did not have any sort of lung disease caused by coal dust exposure. In such a situation, if each type of evidence were evaluated only within a particular subsection of § 718.202(a) to which it related, the x-ray evidence could support an award for benefits in spite of the fact that the more probative evidence established that benefits were not due. *See Griffith v. Director, OWCP*, 49 F.3d 184, 187 (6th Cir. 1995) (noting that autopsy evidence is generally accorded greater weight than x-ray evidence).

The Director took the position that x-ray evidence should not be weighed against medical opinion evidence as these two types of evidence measure different types of pneumoconiosis, *i.e.* clinical versus legal pneumoconiosis. The court agreed that there are two types of pneumoconiosis and stated that "[m]edical pneumoconiosis is a particular disease of the lung generally characterized by certain opacities appearing on the chest x-ray." The court further noted that legal pneumoconiosis encompasses a broader category of coal dust induced respiratory diseases and concluded the following:

> In that sense, the Director's point is well-taken: Evidence that does not establish medical pneumoconiosis, *e.g.*, an x-ray read as negative for coal workers' pneumoconiosis, should not necessarily be treated as evidence weighing against a finding of legal pneumoconiosis.

Under the facts of the present case, the Board affirmed the undersigned's finding that the chest x-ray evidence did not support a finding of pneumoconiosis under § 718.202(a)(1) of the regulations. It is noted that one of Employer's experts, Dr. J. Dale Sargent, who is a pulmonary specialist and B-reader, as well as Claimant's expert, Dr. Emory Robinette, who is also a pulmonary specialist and B-reader, found that many of the negative re-readings did not comply with the ILO-U/ICC classification guidelines. In particular, Dr. Sargent noted that he diagnosed the presence of pneumoconiosis by chest x-ray and that

"[a]lthough x-rays showing t opacities are unusual in patients with coal workers' pneumoconiosis, it is not unheard of." He observed that some board-certified radiologists and B-readers interpreted the miner's x-rays as negative, while noting the presence of opacities and interstitial fibrosis. According to Dr. Sargent, although these physicians attributed the findings to other disease processes including asbestosis or smoking, they should have classified the studies as Category 1 pneumoconiosis. Dr. Robinette agreed and stated that he had reviewed numerous negative x-ray interpretations and nevertheless concluded that the disease was present:

> This is based on my separate x-ray interpretation as well as reviewing a variety of interpretations submitted by renown physicians who recognize an interstitial component to the radiographic abnormalities but consistently under-read those interstitial markings as not consistent with pneumoconiosis which do not follow the guidelines by the 1980 ILO x-ray series.

The undersigned has reviewed the negative x-ray reports of record and it is noted that the observations of Drs. Sargent and Robinette are persuasive in that other physicians found the presence of opacities and fibrosis, but declined to classify the study as anything other than negative for pneumoconiosis. Given the discrepancies in interpreting the chest x-ray studies in this record, it is determined that the x-ray evidence does not preclude a finding of legal pneumoconiosis through the medical opinion evidence as established through Judge Roketenetz's decision which was affirmed by the Fourth Circuit.

III
Re-evaluation of the medical opinion evidence under § 718.202(a)(4)

Although the undersigned has adopted Judge Roketenetz's finding of legal pneumoconiosis under § 718.202(a) and Employer has offered no new theories upon which to conclude that the miner did not suffer from the disease, the medical opinion evidence will again be evaluated by the undersigned out of an abundance of caution in accordance with the Board's remand instructions.

Under the amended regulations, "pneumoconiosis" is defined to include both clinical and legal pneumoconiosis:

> (a) For the purpose of the Act, "pneumoconiosis" means a "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
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> > (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine

> employment. The definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201 (Dec. 20, 2000).

Pursuant to 20 C .F.R. § 718.202(a)(4), Claimant may establish that the miner suffered from coal workers' pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. *See Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984).

A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. *Fields, supra*. Indeed, whether a medical report is sufficiently documented and reasoned is for the administrative law judge as the finder-of-fact to decide. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). Moreover, statutory pneumoconiosis is established by well-reasoned medical reports which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. *Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988). An equivocal opinion, however, may be given little weight. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988); *Snorton v. Zeigler Coal Co.*, 9 B.L.R. 1-106 (1986). The following medical reports are in the record:

1. Dr. S.K. Paranthaman initially examined and tested the miner on July 17, 1980 in conjunction with the miner's first claim for benefits. Dr. Paranthaman concluded that the miner suffered from pulmonary

emphysema and chronic bronchitis due to coal dust exposure and/ or tobacco abuse. He noted bilateral wheezing, moderately reduced breath sounds, and prolonged expiration on examination of the lungs.

A second examination was conducted by Dr. Paranthaman on September 13, 1989. *Dx*. 11. He reported a 22 year history of coal mine employment as well as a smoking history of one pack of filtered cigarettes per day for 20 years, where the miner quit smoking 15 years ago. A chest x-ray revealed Category 0 pneumoconiosis. However, Dr. Paranthaman diagnosed the presence of chronic obstructive pulmonary disease arising from coal dust exposure and cigarette smoking. He concluded that the miner was totally disabled due to his severe respiratory impairment "as shown by lung rales, decreased breath sounds, markedly reduced FEV1 and marked hypoxemia at rest." On examination, he noted bilateral basal rales and decreased breath sounds.

2. Dr. Arthur Nash examined and tested the miner and issued his report on April 12, 1990. *Dx*. 38. He reported a 42 years history of coal mine employment as well as a 30 year smoking history of one pack of cigarettes per day, where the miner quit 15 years ago. On examination, Dr. Nash noted expiratory wheezes. A chest x-ray was interpreted as demonstrating Category 2 pneumoconiosis. Blood gas testing produced qualifying values and revealed moderate hypoxemia. Pulmonary function testing also produced qualifying values. Dr. Nash concluded that the miner suffered from chronic obstructive pulmonary disease and coal workers' pneumoconiosis, among other ailments. He attributes "nearly all" of the miner's pulmonary problems to coal dust exposure.

3. On February 12, 1990, Dr. J. Dale Sargent examined and tested the miner and issued his report. He reported a 43 year history of coal mine employment and a 25 to 30 year history of smoking one pack of cigarettes per day. Examination of the lungs revealed "bibasilar crackles" which would not clear with deep breathing. A chest x-ray revealed Category 1, t/t pneumoconiosis. Pulmonary function testing demonstrated severe obstructive ventilatory impairment without evidence of restriction. Dr. Sargent diagnosed the presence of coal workers' pneumoconiosis based on the chest x-ray findings and stated that "[a]lthough x-rays showing t opacities are unusual in patients with coal workers' pneumoconiosis, it is not unheard of." However, Dr. Sargent concluded that the miner suffered from a totally disabling respiratory impairment unrelated to coal dust exposure. He reasoned that the impairment was obstructive, without any evidence of restriction.

Dr. Sargent was deposed on April 29, 1991. *Employer's Exhibit (Ex.)* 6. He concluded that the miner suffered from a severe obstructive respiratory impairment due to his cigarette smoking. *Ex*. 6 at 8-9. Dr. Sargent recalled that he diagnosed the presence of simple coal workers' pneumoconiosis by chest x-ray as 1/1, t/t. *Ex*. 6 at 11. He stated that the changes in the miner's lungs were required to be classified as Category 1 pneumoconiosis, but that the disease was not of the magnitude to cause a ventilatory impairment such as that found in the miner. *Ex*. 6 at 18. Dr. Sargent did not believe that pneumoconiosis contributed to the miner's respiratory impairment, but he could not rule it out as a contributing factor. *Ex*. 6 at 35. He also noted that there was no reversibility on pulmonary function testing after application of a bronchodilator. *Ex*. 6 at 44.

By letter dated June 3, 1991, Dr. Sargent stated that his opinion was unchanged after reviewing the reports of Drs. Renn and Castle.

Dr. Sargent graduated with a Doctor of Medicine in 1979 from the Medical College of Virginia. He is board-certified in internal medicine with subspecialties in pulmonary diseases and critical care.

4. Dr. Joseph Renn reviewed certain medical records and issued his report on April 7, 1991. *Ex*. 7. He noted a 40 to 43 year history of coal mine employment as well as a smoking history of one pack of cigarettes per day for 25 to 37 years. Pulmonary function testing yielded evidence of a moderate, significantly bronchoreversible, obstructive ventilatory defect. Blood gas testing revealed minimal to moderate hypoxemia. Dr. Renn diagnosed chronic bronchitis emphysema complex, but not pneumoconiosis. He concluded that the miner's respiratory condition "resulted from his years of tobacco smoking rather than exposure to coal mine dust." In support of this finding, Dr. Renn stated the following:

> [The miner suffered from] physical findings of wheezing which is not present in coal workers' pneumoconiosis, his history of late onset of productive cough and worsening without exposure to coal mine dust since February 17, 1989 which is uncharacteristic of industrial bronchitis but characteristic of chronic bronchitis, an obstructive rather than restrictive ventilatory defect, a significantly broncho reversible obstructive ventilatory defect, interim improvement or decline of the degree of obstruction as manifested by FVC measurements in 1989 and 1990, radiographic evidence of emphysema the focal emphysema of coal workers' pneumoconiosis being unappreciable radiographically, and the absence of parenchymal opacities consistent with pneumoconiosis.

The undersigned notes that both the pre- and post-bronchodilator results of the testing reviewed by Dr. Renn were qualifying. Thus, even with the use of the bronchodilator, the miner's respiratory capability was not "reversible" to the extent that it was at a non-disabling level for someone his age and height.

Dr. Renn issued a supplemental report on May 24, 1991 after reviewing certain additional medical records. *Ex*. 10. He concluded that the miner suffered from "moderate, significantly bronchoreversible, obstructive ventilatory defect and moderate resting hypoxemia" which resulted in a "chronic bronchitis-emphysema complex" unrelated to coal dust exposure. No further explanation was provided.

Dr. Renn reviewed certain additional medical records and issued a supplemental report on December 14, 1995. *Ex*. 14. He concluded that the miner died from complications of chronic bronchitis emphysema complex which arose from his smoking history. Dr. Renn cited to the miner's "severe, significantly bronchoreversible obstructive ventilatory defect the severity of which was too great to be associated with simple coal workers' pneumoconiosis." Dr. Renn stated that the reversibility of the miner's disease did not support a finding of pneumoconiosis. He concluded that the miner "may have" had "subradiographic" evidence of coal workers' pneumoconiosis.

Dr. Renn was deposed on December 15, 1995. *Ex*. 16. He testified that coal workers'

pneumoconiosis manifests itself as dyspnea on exertion. *Ex*. 16 at 6. Dr. Renn further stated that the disease produces a mild restrictive ventilatory defect with a reduction in total lung capacity and diffusing capacity. *Ex*. 16 at 7. Dr. Renn opined that the disease does not progress in the absence of continued exposure to coal dust. *Ex*. 16 at 8. He concluded that the miner died from a "complication of chronic bronchitis and emphysema, which likely resulted from his chronic hypoxemia." *Ex*. 16 at 10. He noted that the miner:

> . . . had marked difficulty throughout the last two years of his life, a little more than two years, about two and a half, having been admitted to a hospital on 22 occasions, most of the time for treatment of lower respiratory tract infections.

Ex. 16 at 10. Upon review of the medical records, Dr. Renn also concluded that the miner suffered from cor pulmonale with left and right-sided congestive heart failure. *Ex*. 16 at 11. Dr. Renn opined that the miner's right-sided heart failure progressed to the point that it affected the left side. *Ex*. 16 at 12. He stated that the miner suffered from chronic bronchitis arising from his emphysema. *Ex*. 16 at 22. Dr. Renn concluded that the miner did not suffer from coal workers' pneumoconiosis and his death was caused, in part, by his smoking-induced respiratory disease. *Ex*. 16 at 28-29.

Dr. Renn graduated with a M.D. from the West Virginia University Medical Center in 1964 where he currently serves as a Clinical Associate. Dr. Renn is board-certified in internal medicine with a subspecialty in pulmonary diseases. He is also a Pulmonary Disease Consultant at the Monongalic County Chest Diagnostic Clinic.

5. Dr. James Castle reviewed certain medical records and issued a report on April 8, 1991. Dr. Castle concluded that there was "absolutely no evidence" of a substantive change in the miner's respiratory system from the date of his first application for benefits in 1972 until his second application was filed in 1989. He concluded that the miner suffered from a moderate pulmonary impairment and mild hypoxemia at rest with improved oxygenation on exercise which, in Dr. Castle's opinion, supported a finding of chronic obstructive pulmonary disease due to cigarette smoking. Turning to the x-ray evidence of record, Dr. Castle stated the following:

> A very vast majority of B-readers felt that the current radiographs showed no evidence whatsoever of coal workers' pneumoconiosis. It was felt that bullous emphysema as well as some interstitial changes which were felt to be unrelated to coal workers' pneumoconiosis or silicosis. These changes are not typical of those seen with coal workers' pneumoconiosis and in fact may be related to the patient's underlying bullous emphysema.

He further noted that there was no decline in the miner's FVC value on pulmonary function testing since 1980, which indicated the lack of a restrictive defect. Dr. Castle also stated that the fall of the FEV1 was "totally compatible with a further progression of chronic obstructive pulmonary disease due to cigarette smoking." Dr. Castle concluded that the miner did not suffer from coal workers' pneumoconiosis because

of the lack of radiographic findings, lack of a restrictive defect, and a lack of "consistent physical findings."

Dr. Castle reiterated his conclusions that the miner did not suffer from coal workers' pneumoconiosis by report dated May 8, 1991 after reviewing additional chest x-ray evidence. *Ex*. 11.

Dr. Castle again issued a supplemental report on December 18, 1995 wherein he opined that the miner did not suffer from coal workers' pneumoconiosis. *Ex*. 13. He noted that physical examination of the miner revealed rales on multiple occasions, but not on every occasion. He noted that, if coal workers' pneumoconiosis was present, rales would be present on a constant, and not merely intermittent, basis. Moreover, he noted that the "vast majority" of x-ray interpretations were negative for the disease, although the studies revealed the presence of pulmonary emphysema and "increased interstitial markings." Also, Dr. Castle noted that coal workers' pneumoconiosis may cause an obstructive impairment but "it usually does this in conjunction with a restrictive ventilatory defect and that is not present in this case." Finally, Dr. Castle concluded that blood gas studies "showed a very significant degree of hypoxemia during the several years prior to his demise" and that "[t]here were multiple episodes of severe hypoxemia during periods of hospitalization." Dr. Castle found this condition was "most likely" due to the miner's congestive heart failure. He concluded that the miner's respiratory impairment was solely due to his tobacco abuse.

Dr. Castle was deposed on December 20, 1995. *Ex*. 15. He testified that coal workers' pneumoconiosis does not progress after exposure to coal dust ceases. *Ex*. 15 at 8. He stated that coal workers' pneumoconiosis causes a mixed obstructive and restrictive impairment, which is not present here. *Ex*. 15 at 15-16. Dr. Castle also noted that the miner's diffusing capacity was not lower, which does not support a finding of pneumoconiosis. Moreover, he noted that while wheezing and crackles were present, they were not consistently present which also does not support a finding of the disease. *Ex*. 15 at 18. Also, the x-ray evidence revealed irregular types of opacities which "are usually related to some other process. *Ex*. 15 at 18. Dr. Castle stated:

> The question comes up, can (the irregular opacities constitute) coal workers' pneumoconiosis, and the answer is yes, they can occur, but it is far more unlikely to be seen in coal workers' pneumoconiosis alone.

Ex. 15 at 19. He noted that the record also revealed worsening hypoxemia which eventually required oxygen therapy. *Ex*. 15 at 19.

Dr. Castle agreed with Dr. Barongan that the immediate cause of the miner's death was acute respiratory failure and chronic obstructive pulmonary disease. *Ex*. 15 at 25-26. He concluded that it was "apparent that (the miner) had . . . developed progression of his underlying emphysema and tobacco smoke-induced disease with recurrent infections, related bacterial bronchitis, and worsening hypoxemia." *Ex*. 15 at 29. He attributed the miner's worsening hypoxemia to his heart disease and tobacco-induced respiratory insufficiency. *Ex*. 15 at 30. Dr. Castle concluded that the miner would have died at the same time and in the same manner even without coal dust exposure because of his heart disease and respiratory insufficiency unrelated to coal dust exposure. *Ex*. 15 at 31. He did agree that the recurrent respiratory

infections, which were unrelated to coal dust exposure, hastened the miner's death. *Ex*. 15 at 31.

Dr. Castle graduated with a *Doctor of Medicine* from the West Virginia University School of Medicine in 1969. He is a B-reader and is board-certified in internal medicine with a subspecialty in pulmonary diseases. Dr. Castle currently is a Clinical Professor of Medicine at the University of Virginia College of Medicine.

6. On May 21, 1991, Dr. Emory Robinette reviewed certain medical records and concluded that the miner was totally disabled due to coal workers' pneumoconiosis. He noted that varying smoking and coal mine employment histories were provided by the physicians of record. There was a record of 31 to 43 years of coal mine employment as well as a 25 to 37 year history of smoking one pack of cigarettes per day. Dr. Robinette reviewed numerous negative x-ray interpretations, but concluded that the disease was present and reasoned as follows:

> This is based on my separate x-ray interpretation as well as reviewing a variety of interpretations submitted by renown physicians who recognize an interstitial component to the radiographic abnormalities but consistently under-read those interstitial markings as not consistent with pneumoconiosis which do not follow the guidelines by the 1980 ILO x-ray series.

Dr. Robinette further opined that the miner suffered from chronic bronchitic symptom complex, which may have been partially related to his cigarette smoking, but was additionally related to 40 years of coal dust inhalation.

The record also contains the office treatment notes of Dr. Robinette dated October 11, 1991. *Dx*. 8. In these notes, Dr. Robinette stated that "Mr. Sproles has had respiratory disease over the past 20 years but his symptoms have clearly increased in severity over the past year." On examination, he found that the miner was "short of breath on exertion" and "[h]e wheezes, has a cough and congestion." Dr. Robinette also noted the presence of rhonchi, but found no "symptoms of upper airway obstruction." He stated that there was a "moderate prolongation of the expiratory phase." Dr. Robinette concluded that the miner suffered from "occupational pneumoconiosis with significant pulmonary disease."

Office notes dated October 23, 1991 revealed continued respiratory impairment. A chest x-ray demonstrated Category 2/3, q/t pneumoconiosis, pulmonary emphysema, and cor pulmonale. *Dx*. 9. Dr. Robinette noted the pulmonary function testing revealed a "markedly impaired" diffusion capacity at 33 percent of normal. This testing also revealed "moderate severe obstructive lung disease without response to bronchodilator therapy with mild air trapping." Blood gas studies demonstrated "a severe impairment of the diffusion capacity with profound resting hypoxemia." Based on observed radiographic abnormalities, Dr. Robinette diagnosed the miner with complicated coal workers' pneumoconiosis with diffuse interstitial involvement and hypoxemia with a severe impairment of the diffusion capacity related to an air exchange gradient."

The miner was again seen by Dr. Robinette on November 14, 1991 for "his coal workers' pneumoconiosis with associated severe hypoxemia and obstructive airways disease." *Dx*. 10. Examination revealed "diminished breath sounds with diffuse wheezes and inspiratory crackles present in both lung fields." Moreover, Dr. Robinette noted "moderate prolongation of the expiratory phase." On subsequent examinations dated December 13, 1991 and February 5, 1992, Dr. Robinette continued to note diminished breath sounds, wheezing, and crackles. *Dx*. 11.

By report dated January 20, 1995, Dr. Robinette noted that he reviewed the miner's death certificate as well as certain medical records. *Dx*. 37. He stated the following:

> I initially evaluated Mr. Sproles in October, 1991 and as a consequence of that assessment it was felt that Mr. Sproles had evidence of complicated coal workers' pneumoconiosis with diffuse interstitial fibrosis and cor pulmonale. X-rays were interpreted as consistent with pneumoconiosis with a profusion abnormality of 2/3, predominant Q/T opacities and evidence of axillary coalescence with cor pulmonale and a possible category A mass.

Moreover, Dr. Robinette noted that pulmonary function and blood gas testing revealed a "severe impairment of the diffusion capacity." Dr. Robinette diagnosed the presence of coal workers' pneumoconiosis which produced severe hypoxemia and evidence of "profound oxygen desaturation with minimal exercise." Dr. Robinette noted that, despite medication and oxygen treatments, the miner became "largely house confined as a consequence of his endstage pulmonary disease" and he "subsequently expired as a consequence of his endstage lung disease." With regard to the cause of the miner's death, Dr. Robinette stated the following:

> It is my medical opinion that Sproles suffered from an occupational pneumoconiosis which occurred as a direct consequence of his prior coal mining employment. Moreover, his coal workers' pneumoconiosis was associated with a severe obstructive ventilatory impairment with severe hypoxemia and cor pulmonale. In my medical opinion his pulmonary disease was the cause of his death and it is felt that coal workers' pneumoconiosis as a primary disease entity contributed to his death.

Dr. Robinette graduated from Eastern Virginia Medical School in 1978 with a Doctor of Medicine. He is board-certified in internal medicine with a subspecialty in pulmonary diseases. He currently works in Pulmonary Disease, Consultative and Critical Care at Johnston Memorial Hospital and he is the Director of Respiratory Therapy at that hospital.

7. Dr. P. Barongan also examined and treated the miner during his numerous hospitalizations at St. Mary's Hospital. The earliest of these records demonstrate that the miner was hospitalized from March 9, 1992 through March 13, 1992. *Dx*. 13. On admission, Dr. Barongan noted increased dyspnea, swelling of the extremities, and difficulty breathing. Physical examination revealed crackles and clubbing. A chest x-ray demonstrated the presence of advanced interstitial lung disease without change from October 16, 1989. The miner was diagnosed with acute bronchitis which was probably viral in etiology with "exacerbation of

pneumoconiosis and chronic obstructive lung disease."

The miner was again admitted to the hospital from June 12, 1992 through June 29, 1992. *Dx*. 14. Wheezing was heard in the lungs on examination. The final diagnosis by Dr. Barongan was beginning respiratory failure secondary to acute bronchitis with bronchospasm and exacerbation of pneumoconiosis and chronic obstructive pulmonary disease. Dr. Barongan further diagnosed the presence of ischemic heart disease secondary to hypoxemia, pulmonary hypertension with cor pulmonale, and cardiac arrhythmia.

From February 21 to 25 1993, the miner was admitted to the hospital for an upper respiratory tract infection. *Dx*. 15. Wheezes were again heard throughout the lungs and there was clubbing of the fingers and toes secondary to chronic obstructive pulmonary disease. The miner's discharge diagnosis was "acute bronchitis with bronchospasm and exacerbation of pneumoconiosis and chronic obstructive lung disease with severe hypoxemia."

Additional hospitalizations were August 11 to 15, 1993, August 18 to 22, 1993, October 16 to 20, 1993, November 3 to 5, 1993, November 17 to 23, 1993, December 7 to 17, 1993, February 24 to 27, 1994, April 10 to 14, 1994, May 19 to 21, 1994, June 7 to 13, 1994, June 23 to 29, 1994, July 2 to 10, 1994, July 18 to 23, 1994, July 29, 1994, August 27, 1994, September 8 to 16, 1994, September 20 to October 19, 1994, and October 26, 1994. *Dx*. 16-35. Dr. Barongan's diagnoses remained acute bronchitis and exacerbation of pneumoconiosis and chronic obstructive pulmonary disease as well as cor pulmonale. Various examinations revealed wheezing, rales, labored respirations, and scattered rhonchi.

8. The record contains a death certificate completed by Dr. Barongan dated November 21, 1994. *Dx*. 6. He stated that the miner died on November 11, 1994 due to acute respiratory failure and severe chronic obstructive lung disease. Other significant conditions which contributed to the miner's death were arteriosclerotic heart disease with cor pulmonale.

All of the physicians of record conclude that the miner suffered from a totally disabling respiratory impairment. Of these physicians, all of the examining and treating physicians, including Drs. Barongan and Robinette as well as one of Employer's experts, Dr. Sargent, diagnosed the presence of coal workers' pneumoconiosis. Only the non-examining physicians, Drs. Renn and Castle, opine that the miner's respiratory impairment is due solely to his tobacco abuse. Dr. Sargent found occupational pneumoconiosis based upon the chest x-ray evidence, but concluded that the miner's respiratory impairment was unrelated to pneumoconiosis because it produced an obstructive impairment without restriction. As will be discussed, however, the undersigned does not find the opinions of Drs. Renn, Sargent, and Castle to be persuasive given the flawed premises upon which they rest.

All of the physicians of record conclude that the miner suffers from a severe obstructive defect without restriction. Drs. Sargent, Renn, and Castle conclude that this type of defect is not typical of occupational pneumoconiosis. In *Cornett v. Benham Coal Inc.*, 227 F.3d 569 (6th Cir. 2000), the Sixth Circuit held that a medical opinion attributing the miner's respiratory impairment to his smoking history, on

grounds that pulmonary function testing revealed a purely obstructive defect, was not well-reasoned. Similarly, in this case, the undersigned finds that the opinions of Drs. Sargent, Renn, and Castle are not as well-reasoned as the opinion of Claimant's treating physician, Dr. Robinette, who concludes that the miner's obstructive defect is due, in part, to his years of coal dust exposure. Dr. Robinette's opinion is further supported by the opinion of Dr. Barongan, another treating physician, and the findings of Drs. Paranthaman and Nash, who were examining physicians.

Drs. Castle, Renn, and Robinette found that the miner suffered from a reduced diffusing capacity. Dr. Robinette found that the diffusing capacity was "severely reduced" and concluded that this supported a finding of coal workers' pneumoconiosis. Drs. Renn and Castle concluded that occupational pneumoconiosis would not cause a reduction in diffusing capacity unless it was extensive. They find that the miner did not suffer from extensive coal workers' pneumoconiosis because of the negative x-ray readings which the undersigned has found to be unreliable. As a result, the opinions of Drs. Renn and Castle on this issue are not persuasive.

In addition, Dr. Renn's finding that the miner's respiratory impairment was "significantly bronchoreversible" is not supported in the record. Dr. Castle found only "some" reversibility and Dr. Robinette, as well as one of Employer's experts, Dr. Sargent, noted that the pulmonary function testing demonstrated an obstructive lung disease without response to bronchodilator therapy. The undersigned is persuaded by the characterization of Dr. Robinette, which is supported by Dr. Sargent, and it is determined that the preponderance of the physicians' opinions support a finding that the miner's respiratory impairment was not reversible which is consistent with occupational pneumoconiosis.

Further, it is noted that Drs. Renn and Castle relied on chest x-ray interpretations in concluding that pneumoconiosis was not established. Dr. Renn acknowledges, in his December 1995 report, that the miner may have had "subradiographic" evidence of coal workers' pneumoconiosis. Moreover, Dr. Castle stated, in his 1995 deposition, that he did not find the presence of occupational pneumoconiosis "although there was some evidence of some increased irregular markings on some of the films." However, for the reasons previously stated, the undersigned does not find that the x-ray evidence is probative of a finding of legal pneumoconiosis. *See supra* at pp. 4-5. It is further noted that, in *Cornett*, the Sixth Circuit held that the presence of a particular type of fibrosis on the chest x-rays "is not a required element of the broader concept of 'legal' pneumoconiosis." Reliance on the chest x-rays in this case does not lend probative value to the reports of Drs. Renn and Castle.

Another problem with the reports of Drs. Renn and Castle is that they assume that simple pneumoconiosis is not a latent disease which may manifest itself after exposure to coal dust has ceased. Specifically, Dr. Renn does not diagnose the presence of occupational pneumoconiosis because there was a worsening of the miner's symptoms without exposure to coal dust. Dr. Castle, during his 1995 deposition, testified that simple coal workers' pneumoconiosis does not progress in the absence of continued exposure to coal dust. This premise is contrary to the plain language of the amended regulatory provisions at 20 C.F.R. § 718.201(c) which provides that pneumoconiosis is "recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure."

See also LaBelle Processing Co. v. Swarrow, 72 F.3d 1361 (3d Cir. 1995) (pneumoconiosis is a latent lung disease which may manifest itself after exposure to coal dust ceases).

Although I have found no precedents in the Fourth Circuit specifically adopting the holding in *LaBelle*, there are no cases from that circuit, or any other circuit of which I am aware, repudiating its holding. Moreover there are Fourth Circuit cases holding that pneumoconiosis is a progressive disease and strongly suggesting that it can first become detectable after the cessation of coal mine employment. In *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F. 3d 250 (4th Cir. 2000), the circuit court found that a miner whose coal mine employment ended in 1973 had complicated pneumoconiosis where his chest x-rays prior to 1970 were negative for pneumoconiosis, subsequent x-rays were positive for simple pneumoconiosis, and a February 1991 x-ray showed complicated pneumoconiosis. In *Lane Hollow Coal v. Director, OWCP*, 137 F. 3d 799 (4th Cir. 1998), the court affirmed the finding of an administrative law judge that a miner who retired in 1975 had pneumoconiosis where the x-rays from 1974-1980 were negative for pneumoconiosis, but the x-rays from 1981-1985 were positive for pneumoconiosis. Therefore, application of the amended provisions at § 718.201(c) is proper.

The multiple flaws and inconsistencies underlying the reports of Drs. Renn, Castle, and Sargent, render their opinions regarding whether the miner suffers from legal pneumoconiosis to be unpersuasive. On the other hand, the undersigned finds Dr. Robinette's treatment notes and opinions to be highly probative. In *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992), the Fourth Circuit held that "a comparison of medical reports and tests over a long period of time may conceivably provide a physician with a better perspective than a pioneer physician." *See also Revnack v. Director, OWCP*, 7 B.L.R. 1-771 (1985) (the length of time in which a physician has treated the miner is relevant to the weight given to his opinion). In *Grigg v. Director, OWCP*, 28 F.3d 416 (4th Cir. 1994), the court held that, although a claimant's treating physician "was not as highly qualified as the other physicians whose opinions appear in this record, his status as the treating physician entitles his opinion to great, though not necessarily dispositive, weight."

On this record, Dr. Robinette is a highly qualified physician. In particular, he is a B-reader and is board-certified in internal medicine with a subspecialty in pulmonary diseases. He currently serves as the Director of Respiratory Therapy at Johnston Memorial Hospital. His records indicate that he treated the miner since 1991, which constitutes a significant span of time for observation and evaluation of the miner's condition. Consistently, Dr. Robinette noted diminished breath sounds and wheezing during his examinations. His finding of coal workers' pneumoconiosis was based on his chest x-ray interpretations, qualifying pulmonary function testing, and physical examinations. Dr. Robinette's opinion further reveals that he was aware of the miner's lengthy smoking and coal mining histories and he attributed the miner's totally disabling respiratory impairment to both of these conditions. Dr. Robinette's opinion is supported by the treatment notes of Dr. Barongan, who treated the miner during his multiple hospitalizations at St. Mary's Hospital. Hospital records reveal continual, worsening respiratory and pulmonary problems which resulted in the miner's hospitalizations for dyspnea and difficulty breathing. Dr. Barongan diagnosed pneumoconiosis and chronic obstructive lung disease which compromised the miner's lung function. The opinions of Drs. Nash and Paranthaman also support Dr. Robinette's conclusions. Dr. Robinette's opinion

is also entitled to greater weight on this record because it is based on more extensive medical data, including multiple examinations and testing of the miner as well as a review of other medical records, which provided him with a more complete assessment of the miner's condition. *Sabett v. Director, OWCP*, 7 B.L.R. 1-229 (1984); *Stark v. Director, OWCP*, 9 B.L.R. 1-36 (1986). *See also Jones v. Badger Coal Co.*, 21 B.L.R. 1-103 (1998)(en banc) (it is within the administrative law judge's discretion as the trier-of-fact to accord greater weight to the miner's treating physician and another physician who treated the miner during his multiple hospitalizations over the opinions of non-examining physicians).

As a result, the preponderance of the probative medical opinion evidence supports a finding that the miner suffers from coal workers' pneumoconiosis under 20 C.F.R. § 718.202(a)(4) and this finding is not altered by the preponderantly negative chest x-ray evidence of record which, as previously noted, the undersigned has concluded is not probative of the existence of pneumoconiosis in this case.

Establishing Death Due to Pneumoconiosis

Benefits are provided under the Act for survivors of miners who died due to pneumoconiosis. 20 C.F.R. § 718.205. The regulations at § 718.205 require competent medical evidence which (1) establishes that the miner died due to pneumoconiosis; or (2) that pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis; or (3) that the presumption of § 718.304 is applicable.[2]

The Board has held that the record must demonstrate that "the cause of death is significantly related to or significantly aggravated by pneumoconiosis" to satisfy the requirements of § 718.205 of the regulations. *Foreman v. Peabody Coal Co.*, 8 B.L.R. 1-371, 1-374 (1985). However, the Third, Fourth, Sixth, and Seventh Circuits have held that if pneumoconiosis "hastens" the miner's death, then it is a "substantially contributing cause" of his death. *Brown v. Rock Creek Mining Corp.*, 996 F.2d 812 (6th Cir. 1993)(J. Batchelder dissenting); *Peabody Coal Co. v. Director, OWCP*, 972 F.2d 178 (7th Cir. 1992); *Shuff v. Cedar Coal Co.*, 967 F.2d 977 (4th Cir. 1992); *Lukosevicz v. Director, OWCP*, 888 F.2d 1001 (3d Cir. 1989).

Of the physicians who addressed the etiology of the miner's death, Drs. Renn and Castle conclude that death was not hastened by coal workers' pneumoconiosis. Although Dr. Castle stated that the miner's death would not have been due to the disease, even if it were present, he did not provide a reasoned or documented explanation in support of this cursory opinion. All of the physicians agreed with Dr. Barongan's conclusion on the miner's death certificate that the miner died as a direct result of acute respiratory failure and severe chronic obstructive lung disease. Drs. Renn and Castle concluded that the

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[2] Because there is no evidence of complicated pneumoconiosis in this record, the presumption at § 718.304 is inapplicable and will not be discussed further. Moreover, the lay evidence provisions at § 718.204(c)(5) are inapplicable to this survivor's claim because it was filed after January 1, 1982. *See also Gessner v. Director, OWCP*, 11 B.L.R. 1-1, 1-3 (1987).

miner's death was due, in part, to his smoking-induced respiratory disease. However, the undersigned accords their opinions little weight in light of the fact that they did not diagnose the presence of coal workers' pneumoconiosis. Dr. Robinette, on the other hand, found that coal workers' pneumoconiosis did contribute to the miner's death and the undersigned is persuaded by his opinion given his history as the miner's treating physician and his review of the records in this case.

In *Compton*, the administrative law judge found the presence of coal workers' pneumoconiosis by medical opinion evidence, but not through the chest x-ray evidence. As a result, the Fourth Circuit held that it was proper for the administrative law judge to give less weight to the opinions of physicians who did not consider legal pneumoconiosis as a possible cause of the miner's total disability, where the administrative law judge found that the disease was established on the record. Similarly, in this case, the undersigned has found that pneumoconiosis is established after weighing all of the evidence under § 718.202(a). The opinions of Drs. Renn and Castle are based on their failure to diagnose the disease such that the undersigned does not find the opinions persuasive. Dr. Robinette, on the other hand, persuasively explains that coal workers' pneumoconiosis contributed to the miner's overall respiratory impairment which produced severe hypoxemia and resulted in the miner's death. Hospitalization records immediately preceding the miner's death lend support to Dr. Robinette's conclusions. Specifically, these records reveal a severely compromised respiratory system which was not responsive to oxygen or inhalers. As a result, the undersigned concludes that Claimant has established that legal pneumoconiosis hastened the miner's death as required by 20 C.F.R. § 718.205(c).

Onset of Benefits

Where the claimant is an eligible survivor of the miner and entitled to benefits under the Act, as in this case, such benefits must be paid beginning with the month of the miner's death but, in no instance, before January 1, 1974. 20 C.F.R. § 725.503(c). The survivor in this claim is entitled to benefits from November of 1994, the month in which the miner died. Accordingly,

ORDER

IT IS ORDERED that the claim for benefits filed by Hazel Sproles is granted and benefits are payable commencing as of November 1994.

IT IS FURTHER ORDERED that, on or before July 27, 2001, Claimant's counsel shall file, with this Office and with opposing counsel, a petition for a representatives' fees and costs in accordance with the regulatory requirements set forth at 20 C.F.R. § 725.366. Counsel for the Director and Employer shall file any objections with this Office and with Claimant's counsel on or before August 17, 2001. It is requested that the petition for services and costs clearly state (1) counsel's hourly rate and supporting argument or documentation therefor, (2) a clear itemization of the complexity and type of services rendered, and (3) that the petition contains a request for payment for services rendered and costs incurred before this Office only as the undersigned does not have authority to adjudicate fee petitions for work performed

before the district director or appellate tribunals. *Ilkewicz v. Director, OWCP*, 4 B.L.R. 1-400 (1982).

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Thomas M. Burke
Associate Chief Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.